		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044552

Facility Name: Faith Care Center

Address: 100 Faith Drive (Number) Highland (City) 62249 (Zip Code)

County: Madison

Telephone Number: 618-654-4600 **Fax #** 618-654-4604

IDPA ID Number: 371057583002

Date of Initial License for Current Owners: 03/21/03

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501©(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Lisa Ketrow **Telephone Number:** 618-654-4600

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/03 to 04/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 10/27/04 (Date)
(Type or Print Name) Gerald Harman
(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 03/21/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,692	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	14	Sheltered Care (SC)	14	5,124	5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	15,375	6,186		21,561	10
11	ICF/DD					11
12	SC		4,033		4,033	12
13	DD 16 OR LESS					13
14	TOTALS	15,375	10,219		25,594	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.01%

D. How many bed-hold days during this year were paid by Public Aid? 5 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Senior Community Meal Program

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/30/03

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 03/01/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 8 and days of care provided 0

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 04/30/04 Fiscal Year: 04/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	186,717	17,265	3,115	207,097	13,027	220,124	(13,650)	206,474			1
2	Food Purchase		196,619		196,619	(29,952)	166,667		166,667			2
3	Housekeeping	125,542	12,040	574	138,156	(68,838)	69,318		69,318			3
4	Laundry					68,838	68,838		68,838			4
5	Heat and Other Utilities			117,193	117,193		117,193		117,193			5
6	Maintenance	40,984	17,560	2,935	61,479		61,479		61,479			6
7	Other (specify):* trash removal			1,934	1,934		1,934		1,934			7
8	**TOTAL General Services**	353,243	243,484	125,751	722,478	(16,925)	705,553	(13,650)	691,903			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	1,127,840	60,697	11,124	1,199,661	(1,996)	1,197,665		1,197,665			10
10a	Therapy											10a
11	Activities	61,337	3,252		64,589		64,589		64,589			11
12	Social Services	35,073	2		35,075		35,075		35,075			12
13	Nurse Aide Training	4,511		332	4,843	2,619	7,462		7,462			13
14	Program Transportation		1,130		1,130		1,130		1,130			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,228,761	65,081	18,056	1,311,898	623	1,312,521		1,312,521			16
	C. General Administration											
17	Administrative	90,046		1,432	91,478		91,478	(724)	90,754			17
18	Directors Fees											18
19	Professional Services			14,146	14,146		14,146		14,146			19
20	Dues, Fees, Subscriptions & Promotions			27,688	27,688	1,203	28,891	(21,717)	7,174			20
21	Clerical & General Office Expenses	38,124	20,947	18,518	77,589		77,589		77,589			21
22	Employee Benefits & Payroll Taxes			344,637	344,637	15,099	359,736		359,736			22
23	Inservice Training & Education			25	25		25		25			23
24	Travel and Seminar			2,350	2,350		2,350		2,350			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,441	55,441		55,441		55,441			26
27	Other (specify):*											27
28	**TOTAL General Administration**	128,170	20,947	464,237	613,354	16,302	629,656	(22,441)	607,215			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,710,174	329,512	608,044	2,647,730		2,647,730	(36,091)	2,611,639			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Faith Care Center #0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			437,968	437,968		437,968	(185,888)	252,080			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			876,450	876,450		876,450	(3,357)	873,093			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,314,418	1,314,418		1,314,418	(189,245)	1,125,173			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			150	150		150		150			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,038	34,038		34,038		34,038			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			34,188	34,188		34,188		34,188			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,710,174	329,512	1,956,650	3,996,336		3,996,336	(225,336)	3,771,000			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	13,650	V-1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	3,357	V-32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	21,717	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	186,612			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 225,336		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 225,336		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Faith Care Center

ID# 0044552

Report Period Beginning: 05/01/03

Ending: 04/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Senior Meal Program	$ (13,650)	1	1
2	Interest	(3,357)	32	2
3	Resident and Staff Gifts	(724)	17	3
4	Newsletter	(675)	20	4
5	Advertising-Promo	(22)	20	5
6	Marketing	(21,020)	20	6
7	Assisted Living Depreciation	(185,888)	30	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(225,336)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(13,650)	0	0	0	0	0	0	0	0	0	0	(13,650)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,650)	0	0	0	0	0	0	0	0	0	0	(13,650)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(724)	0	0	0	0	0	0	0	0	0	0	(724)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,717)	0	0	0	0	0	0	0	0	0	0	(21,717)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,441)	0	0	0	0	0	0	0	0	0	0	(22,441)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,091)	0	0	0	0	0	0	0	0	0	0	(36,091)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(185,888)	0	0	0	0	0	0	0	0	0	0	(185,888)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,357)	0	0	0	0	0	0	0	0	0	0	(3,357)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(189,245)	0	0	0	0	0	0	0	0	0	0	(189,245)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(225,336)	0	0	0	0	0	0	0	0	0	0	(225,336)	45

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
n/a						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	n/a								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mortgage Interest						$	$			$ 873,093	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Finance chrgs pd to vendors										3,357	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 876,450	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 876,450	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ n/a	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Faith Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0044552

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,963 B. General Construction Type: Exterior Vinyl Siding Frame Wood/Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

FCH Apts - Phase I, Independent Living, 56 units
FCH Apts - Phase II, Independent Livng, 28 units
FCH Village Condos, Independent Living, 18 units
FCH Village Homes, Independent Living, 33 units
FCH Countryside Center, Independent Senior Citizen Center
FCH Assisted Living, 36 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	372,874	1989	$ 18,549	1
2					2
3	TOTALS	372,874		$ 18,549	3

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		2003	2003	$ 7,334,181	$ 244,083	31	$ 244,083	$	$ 259,918	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,334,181	$ 244,083		$ 244,083	$	$ 259,918	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 889,612	$ 7,997	$ 7,997	$	5-20 yrs	$ 44,983	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 889,612	$ 7,997	$ 7,997	$		$ 44,983	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Van	1997	$ 35,436	$	$	$	5	$ 35,436	76
77	Maintenance	Truck	1998	2,682				5	2,682	77
78										78
79										79
80	TOTALS			$ 38,118	$	$	$		$ 38,118	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,280,460	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 252,080	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 252,080	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 343,019	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 88

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			82		82
3	Classroom Wages	(a)		2,944		2,944
4	Clinical Wages	(b)		1,567		1,567
5	In-House Trainer Wages	(c)		2,619		2,619
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			250		250
9	TOTALS		$	$ 7,462	$	$ 7,462
10	SUM OF line 9, col. 1 and 2	(e)	$ 7,462			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Faith Care Center # 0044552 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 04/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 34	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	191,105		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,213		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 221,352	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	18,549		13
14	Buildings, at Historical Cost	13,048,502		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	916,420		16
17	Accumulated Depreciation (book methods)	(549,327)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	673,749		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing	506,673		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,614,566	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,835,918	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 559,377	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,646		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	69,051		33
34	Deferred Compensation	4,495		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Provider Tax Payable	2,790		36
37	AP Related Parties	426,459		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,170,818	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	13,364,642		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	AP Related Parties	206,755		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 13,571,397	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 14,742,215	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 93,703	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,835,918	$	48

***(See instructions.)**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 959,035	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 959,035	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(865,332)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (865,332)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 93,703	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,757,403	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,757,403	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	173	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	240	13
14	Non-Patient Meals	39,438	14
15	Telephone, Television and Radio	4,247	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,098	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	336	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 336	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	36,256	27
28	Forgiveness of Debt	290,400	28
28a	Van run charges	2,511	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 329,167	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,131,004	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	722,478	31
32	Health Care	1,311,898	32
33	General Administration	613,354	33
	B. Capital Expense		
34	Ownership	1,314,418	34
	C. Ancillary Expense		
35	Special Cost Centers	150	35
36	Provider Participation Fee	34,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,996,336	40
41	**Income before Income Taxes (line 30 minus line 40)****	(865,332)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (865,332)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,980	2,091	$ 44,543	$ 21.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,863	6,637	136,129	20.51	3
4	Licensed Practical Nurses	20,223	21,795	352,252	16.16	4
5	Nurse Aides & Orderlies	57,917	62,262	585,114	9.40	5
6	Nurse Aide Trainees	675	675	4,511	6.68	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,967	2,095	21,600	10.31	9
10	Activity Assistants	3,779	4,139	39,737	9.60	10
11	Social Service Workers	2,306	2,665	35,073	13.16	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,000	26,016	13.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,614	21,866	160,701	7.35	15
16	Dishwashers					16
17	Maintenance Workers	3,882	4,172	40,984	9.82	17
18	Housekeepers	7,812	8,311	62,771	7.55	18
19	Laundry	7,812	8,311	62,771	7.55	19
20	Administrator	2,902	3,131	90,046	28.76	20
21	Assistant Administrator					21
22	Other Administrative	3,790	3,910	38,124	9.75	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction	128	128	2,619	20.46	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	821	821	7,183	8.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,471	155,009	$ 1,710,174 *	$ 11.03	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	89	$ 3,115	1-3	35
36	Medical Director	132	6,600	9-3	36
37	Medical Records Consultant	435	5,659	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	1,500	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	716	$ 16,874		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Robinson	Exec Director	0	$ 26,551
Terrence Riffel	Exec Director	0	1,423
Gerald Harman	Exec Director	0	6,397
Darlene Genteman	Administrator	0	55,675
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,046

B. Administrative - Other

Description	Amount
Meeting Expense	$ 733
Resident Gifts	699
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,432
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Larson, Allen & Weishair &Co	Audit	$ 12,990
Hinshaw & Culbertson	Legal	378
Johannes & Marron, PC	Legal	778
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,146

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,626
Unemployment Compensation Insurance	537
FICA Taxes	131,278
Employee Health Insurance	123,276
Employee Meals	16,302
Illinois Municipal Retirement Fund (IMRF)*	
Retirement (401k)	8,170
CPR Cards	156
Awards	1,026
Barcodes for timeclocks	93
Prescriptions	272
TOTAL (agree to Schedule V, line 22, col.8)	$ 359,736

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 750
Advertising: Employee Recruitment	677
Health Care Worker Background Check	1,203
(Indicate # of checks performed 100)	
Newsletter	675
Advertising/Marketing	21,042
Membership Dues	3,739
Professional Subscriptions/Books	805
Less: Public Relations Expense	( )
Non-allowable advertising	(21,717)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,174

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached	2,350
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,350

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Faith Care Center # 0044552 Report Period Beginning: 05/01/03 Ending: 04/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **LSN-$3,625**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **n/a**
What was the average life used for new equipment added during this period? **n/a**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,048** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **34,038**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,302** Has any meal income been offset against related costs? **no** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **yes**
If YES, attach a complete explanation. St. Louis, Missouri
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **Pending-will forward when complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.

Faith Care Center
Provider #0044552

RECLASSIFICATIONS - Column 5 - Page 3

	Line #		
Housekeeping Salaries	3	(62,771)	Reclass Laundry Salaries
Laundry Salaries	4	62,771	Reclass Laundry Salaries
Housekeeping Supplies	3	(6,067)	Reclass Laundry Supplies
Laundry Supplies	4	6,067	Reclass Laundry Supplies
Dietary Expense	1	(623)	Reclass Dietary Consultant
Nursing Expense	10	623	Reclass Dietary Consultant
Dietary Expense	1	13,650	Reclass Senior Meal food for adj
Food Expense	2	(13,650)	Reclass Senior Meal food for adj
Food Expense	2	(16,302)	Reclass Employee Meals food
Employee Benefits	22	16,302	Reclass Employee Meals food
Dues, Fees, Subscriptions	20	1,203	Reclass Employee Background Checks
Employee Benefits	22	(1,203)	Reclass Employee Background Checks
Nursing Salaries	10	(2,619)	Reclass RN Salaries to C.N.A. training
Nurse Aide Training	13	2,619	Reclass RN Salaries to C.N.A. training

Faith Care Center
Provider #0044552

Schedule VI - Page 5 - Line 29

	Amount	Reference
Gifts	724	V-17
Assisted Living Depreciation	185,888	V-30

Faith Care Center
Provider #0044552

Schedule XIX-Section G-Seminar Expesnse

Date	Name	Conference/Seminar	Expense	Amount
5/30/2003	Rick Embry	LSN Conference (Chicago)	Mileage	108
5/30/2003	Debbie Burgess	St. Louis Community College	Cost	24
5/30/2003	CPR Advantage	Nursing Employees	CPR Cards	173
6/24/2003	Sandra Robinson	First Aid Course (Springfield)	Cost of Seminar	111
7/31/2003	Carmen Garner	Alzheimer's Meeting (Alton)	Travel	23
7/31/2003	Karen Little, Mark Robinson	Implementing Illinois New Medicaid Reimbursement System	Cost of Seminar	190
8/14/2003	Rick Embry	New Life Safety Code (Life Services Network) Springfield)	Cost of Seminar	41
8/31/2003	Debbie Burgess	CDM Credentialing Exam (Pathway II) St. Louis, MO	Cost of Exam	310
9/9/2003	Herschel Austin	Southwestern Illinois College (Adv. Elect Controls & Systems	Tuition	27
9/30/2003	Darlene Genteman	Senior Celebration (Memorial Hospital) Belleville)	Fee	20
9/30/2003	Darlene Genteman, Rick Embry	Safety & Health Conference (Life Service Network) Mt. Vernon	Cost of Seminar	84
9/11/2003	Darlene Genteman	Madison County Mental Health Board (Edwardsville)	Training	45
10/31/03	Sherri Powell & Karen Little	Home Pharmacy Services (Nursing Annual Fall Conference)	Training	110
11/18/03	Denise Sauerwein	IL Dept of Professional Regulation (Springfield)	Testing	208
########	Darlene Genteman	Gateway Hospital (Mental Health Networking Meeting)	Mileage	13
########	Mark Robinson, Darlene Genteman	Life Services Network (Fall Institute) Springfield)	Registration, Mileage, Meals	478
########	Darlene Genteman	St. John's (Collinsville)	Mileage, Meal	45
########	Lisa Ketrow	ADP Training (Payroll System) St. Louis	Mileage, Meal	17
########	Denise Sauerwein	IL Dept of Professional Regulation (Springfield)	Fee	260
12/04/03	Sherri Powell	Our Lady of the Snows - Nurses Meeting - Belleville	Mileage	66
				2,350

Faith Care Center
Board Of Directors

Steve Thiems, President
R.Sam Schwarztrauber, Vice-President
Julie Mason, Secretary
Anold Meyer, Treasurer

Steve Hanna
Rev. John Klueter
James Rankin, Sr
Robert Sudhoff
Bill Aschbacher
Dr. Tom Barker
George Jones
Pete Pisaneschi
Sally Ferguson
Mark Goestenkors
Rev. David Martin
Kirk Pacatte
Sue Sullivan
Terry Riffel